August 12, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-1608-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Physical Medicine and Rehabilitation. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

This patient is a 50-year-old woman who fell at work on ___ and injured her back. She had extensive conservative treatment and as found to have degenerative discs at the L4/5 and L5/S1 levels. She had a discogram done on 7/24/01 by ___ that identified L4/5 and L5/S1 degenerative discs with annular tears and epidural leaks. She underwent surgery for L4/5 and L5/S1 on April 11, 2002.She had right lower extremity pain post-op and was given a series of lumbar epidural injections and a sympathetic block. When her pain persisted, she was given a TENS unit and a muscle stimulator. The RS-4i seemed to decrease her need for medication. Since she had relief of pain with the RS-4i four-channel interferential stimulator on a temporary basis, the unit was ordered for her to use on an ongoing basis at home. The carrier reviewed the information and declined coverage based on the opinions of ___ and ___ orthopaedic surgeons.

REQUESTED SERVICE

A RS-4i four-channel combination interferential and muscle stimulator unit is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

According to the records provided, the treating doctor tried the RS-4i four-channel combination interferential and muscle stimulator unit. The patient had decreased pain and decreased use of medications. Clinically, the unit was effective with her. The quotations form ___ and ___ were very non-specific about medical necessity and the peer review articles that they were quoting seemed to be the same quotes used for all denials of services or equipment.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 12th day of August 2003.